COURT-ORDERED TREATMENT AND INVOLUNTARY - ISOLATION GUIDELINES FOR THE CONTROL OF TUBERCULOSIS

Utah Department of Health
Bureau of Communicable Disease Control
Tuberculosis Control/Refugee Health Program
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I. PURPOSE:

GUIDELINE FOR COURT-ORDERED TREATMENT AND INVOLUNTARY-ISOLATION OF NONADHERENT CLIENTS WITH TUBERCULOSIS

In partnership with the local health departments (LHDs) and health care providers, the Utah Department of Health is responsible for implementation of the Utah Health Code, Title 26, Chapter 6b, *Communicable Diseases - Treatment, Isolation, and Quarantine Procedures*. This statute delineates the process for ordering involuntary treatment, isolation, and quarantine of persons with public endangering communicable diseases that are unable or unwilling to fully participate in their prescribed treatment.

The purpose of this manual and sample documents is to serve as a reference and guideline for court-ordered treatment, quarantine, and isolation of individuals who pose a threat to public health due to infection with Active Tuberculosis Disease (ATBD). This manual is intended to be a useful tool that will simplify and facilitate the process of court-ordered treatment, involuntary-isolation when less restrictive measures are ineffective. Following these guidelines will assure that public health interventions are enforceable and the rights of the client are respected.

Appropriateness of Court-Ordered Treatment and Involuntary-Isolation

Within the context of tuberculosis disease, the first priority of public health is to prevent further transmission of tuberculosis in the community by an infectious individual. This is accomplished by identifying all persons with active tuberculosis and ensuring appropriately prescribed treatment is completed. **In order to safeguard appropriate use of scarce resources and comply with the civil liberty rights of the individual, it is recommended that the less restrictive levels of care be pursued aggressively before progressing to more restrictive levels.** The levels of care are:

> **Level of Care 1:** prescribed outpatient treatment provided by a health care provider, clinic, or LHD for those individuals both willing and able to fully participate in the treatment of their tuberculosis disease. Prescribed treatment shall be provided through the use of directly observed therapy (DOT). The use of incentives and enablers may also be provided to encourage client adherence to treatment.
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> **Level of Care 2:** enhanced surveillance for individuals who indicate an unwillingness or inability to undergo prescribed medical treatment, or have demonstrated poor adherence to treatment that has been previously initiated. Options may include additional incentives, utilization of a “treatment contract”, and counseling regarding the consequences of non-adherence. Implementation of these additional measures ensures completion of treatment.
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> **Level of Care 3:** secure/locked hospital unit or facility offering negative pressure isolation and staff trained in tuberculosis control for accommodating infectious or potentially infectious clients who have failed adherence to treatment at less restrictive levels of care.

Level of Care 4: secure/locked housing such as long term care settings or correctional facilities, for those persons who have not responded to Level 3 strategies and are **noninfectious**. Adequate measures are provided that minimize/eliminate the flight risk of these individuals.

The Advisory Council for the Elimination of Tuberculosis defines *nonadherent behavior* as the inability or unwillingness to follow a prescribed treatment regimen. This may be demonstrated by refusing medication, taking medication inconsistently, missing health provider appointments, or failing to report for directly observed therapy (DOT). Individuals appropriate for court-ordered evaluation may also include contacts of active TB cases that are flight risks.

Although many health care providers believe they can predict a client's adherence to treatment, research indicates their predictions are correct only about 50% of the time.[1] **The strongest predictor of adherence to treatment is the client's history of adherence. The strongest predictor of future adherence problems is a history of nonadherence to treatment, particularly with TB medications.** If there is documentation of nonadherence with previous TB treatment or preventive therapy, it is unlikely that the client will be successful in adhering to the current treatment regimen.

Other indicators for high-risk of nonadherence include: history of other medical treatment nonadherence; substance abuse; mental, emotional, or certain physical impairments that interfere with ability to self-administer medications; children; and adolescents. It is recommended that health care providers formally evaluate each client's potential nonadherence at the time TB medication is prescribed. The issue of treatment adherence is addressed in detail in the publication *Improving Patient Adherence to Tuberculosis Treatment,* U. S. Department of Health and Human Services, and Centers for Disease Control and Prevention (1994). This is an excellent resource that is available without charge.

The purpose of the following information is to assist local health departments in completing the process of establishing court-ordered treatment and involuntary- isolation.

[1] Improving Patient Adherence to Tuberculosis Treatment, U. S. Department of Health and Human Services, Centers for Disease Control and Prevention, 1994.

II. INCENTIVES AND ENABLERS:

STEPS BEFORE COURT-ORDERED TREATMENT AND INVOLUNTARY-ISOLATION

Local health departments and other agencies or facilities that treat tuberculosis infection and disease encourage client adherence to treatment by using incentives and enablers. Incentives are "small rewards given to patients either to encourage them to take their own medicines or to entice them to maintain regular clinic visits or field visits for DOT. Enablers are those things that 'enable' the patient to receive treatment."[2] Enablers ease the difficulty of receiving and completing treatment, and assisting the client to overcome barriers to adherence. **Both incentives and enablers are most effective when individualized to each client's needs and interests.**

Incentives and enablers are alternative strategies included in **Levels of Care 1 and 2**. Consider their use when evaluating a nonadherent client. While incentives and enablers are more expensive than providing TB medication alone, it is a far less costly process than court-ordered treatment. **It is important to attempt to exhaust the incentive/enabler option before proceeding to more restrictive options, from a viewpoint of both resource allocation and preservation of individual civil liberties.** It may be necessary to modify or broaden the initial plan for incentives/enablers if the individual fails to respond. The use of incentives and enablers may facilitate and ensure completion of treatment and ward off implementation of the more restrictive and costly measures of **Level of Care 3 and 4** that encompass court-ordered treatment and involuntary-isolation in a secure/locked facility. Incentives and enablers should not be thought of as rewards for adherence to treatment, "good" behavior, or for being a "likeable" individual. From a public health standpoint incentives/enablers are intended to help with completion of therapy when an individual, for whatever reason, is not motivated or able to complete treatment.

In addition to *Improving Patient Adherence to Tuberculosis Treatment,* another excellent resource is *TB Enablers and Incentives* by the American Lung Association of South Carolina and South Carolina Department of Health and Environmental Control (1989). This booklet provides practical guidelines for implementation of incentives and enablers as well as examples of each.

[2] Improving Patient Adherence to Tuberculosis Treatment, pg. 23.

III. DOCUMENTATION OF NONADHERENCE

Local health departments and providers are encouraged to use the approach and suggestions outlined in *Improving Patient Adherence to Tuberculosis Treatment* to ensure successful completion of recommended treatment. Documentation of a history of nonadherent behavior and steps taken by public health authorities in response to nonadherence is very important in order to provide sufficient evidence and establish grounds to issue court-ordered treatment and involuntary-isolation. The court reviews this "evidence" and the individual has a right to be represented by an attorney. The following may be helpful in providing this documentation.

Contractual Agreement to Treatment

This document explains the need for treatment, a description of treatment (medication regimen and required medical follow up), the importance of completing treatment, possible consequences if treatment is not completed, and the authority of public health officials to ensure adequate and complete treatment to protect public health. This document should be considered for all patients diagnosed with ATBD at the beginning of treatment as it is difficult to predict who will go on to be nonadherent. See: http://www.health.utah.gov/cdc/tbrefugee/forms/lhd_tbTreatmentplan.pdf for an example.

A verbal explanation of the provisions of this document (with an interpreter present if indicated) should be given and the agreement signed by the client and health care provider. Contact the Utah Department of Health, Tuberculosis Control Program for translation assistance, if needed.

Record of Provider Contacts/Treatment

Documentation of appointment dates kept/missed, follow up efforts, phone calls made, letters sent, home/facility visits, DOT, use of incentives, and other pertinent information can be recorded using this form.

Written Affidavit for Temporary Order

Once it is determined that court-ordered treatment or involuntary-isolation is necessary, the LHD or UDOH must submit a written affidavit for a temporary order. The written affidavit must include a statement of belief that the individual (or client) is "subject to supervision," is likely to fail to submit to treatment, that this poses a public health threat, personal knowledge of the individual's condition or circumstances that lead to that belief, and the written statement by a medical doctor.

Procedure for managing persons with suspected or confirmed active TB disease who are at risk to be lost to follow up or who become lost to treatment

1. As part of the initial assessment the PHN will conduct an initial client assessment and follow-up assessments to identify the potential for a client to become lost to follow up This assessment will be conducted within 48 hours of notification.
   Risk factors to be considered are:
   a. history of substance abuse
   b. recent arrest record
   c. homelessness or unwillingness or inability to provide a personal address
   d. lack of a job or visible means of support
   e. lack of family or other community ties
   f. history of leaving the medical facility against medical advice

2. A person with one or more of these risk factors will be classified as a high risk for flight and should be actively case managed with early intervention whenever there is a question of non-compliance.

3. Identification of possible interventions include:
   a. incentives and enablers for achieved outcomes (tie them to achievement of outcomes such as all scheduled DOT appointment for the week). Add incentives for achievement of targeted goals.
   b. short term housing
   c. long term housing
   d. regular case management reviews with referrals for other social service as indicated
   e. a formal written DOT agreement and contract, which specifies who to contact if DOT appointment cannot be kept on an individual day.
   f. alternate contact information, addresses, phone numbers where client may be located.
   g. documentation of all actions and outcomes with the possibility of legal action should outcomes fail.
   h. ongoing patient education

4. Confidentiality is to be maintained during this investigation. A picture may be used if prior written consent has been obtained.

5. Initiating a search for a missing client:

Places to search	who will call/visit	Date	Phone	Outcome
Clients emergency contacts				
Clients emergency contacts				
Individuals identified in CI				
Registered letter with return receipt				
Fourth Street Clinic	Case Mgt		364 0139	
Road Home			359 4142	
Midvale Winter Shelter	Case Mgt		364 0139	
Rescue Mission			355 1302	
St. Vincent's Soup Kitchen			363 7710	
Eagle Ranch 7-11am Sunday				
Good Samaritan Program			328 5633	
VOA Detox			363 9400	
VOA Outreach				
UUMC	Infection Control Nurse		585 3124	
LDS Hospital	Infection Control Nurse		408 3024	
SLRMC	Infection Control Nurse		350 8127	
VA Hospital	Infection Control Nurse		582 1565 ext 1708	
IMC	Infection Control Nurse		507 7782	
St. Mark's Hospital	Infection Control Nurse		268 7848	
ADC	Nursing Supr		743 5554	
SLVHD County Investigator	Nursing Supr		534 4617 or 4674	
Parole/Probation Officer/Community Police Officer				
HIV/STD data base	State TB Nurse Consultant		538 9906	
Neighboring county health dept/shelters	State TB Nurse Consultant		538 9906	
Neighboring state TB programs	State TB Nurse Consultant		538 9906	
Hangouts client is known to frequent				
Landlord/employer if any				
Medicaid office				
WIC if female or child <5				

MONTHLY TUBERCULOSIS DRUG MONITORING FOR TOXICITIES
Beginning with Month Rx Started

Name	Health Dept.	Date

First Line Drugs	Please Check for Untoward Signs and/or Symptoms. If present, indicate (+) if absent, indicate (-)									
ISONIAZID Dosage Mg	# Meds Delivered	# Pills Not Taken								
Comments	Peripheral Neuritis (tingling or muscle twitching)									
	Jaundice (yellow eyeballs or skin)									
	Brownish urine (i.e., “coffee”, “coke”)									
	Light (clay colored) stools									
	Rash									
	Loss of appetite / Nausea									
	Malaise / Fatigue									
RIFAMPIN Dosage Mg	# Meds Delivered	# Pills Not Taken								
Comments	Epigastric disturbances (i.e., nausea, vomiting, diarrhea)									
	Fatigue									
	Dark and/or orange urine									
	Rash or excessive bruising									
	Jaundice (yellow eyes or skin)									
PYRAZINAMIDE Dosage Mg	# Meds Delivered	# Pills Not Taken								
Comments	Joint pain									
	Jaundice (yellow eyes or skin)									
	Dark urine									
	Light (clay colored) stools									
	Upset stomach									

	Rash										
	Malaise / Fatigue										
MONTHLY TUBERCULOSIS DRUG MONITORING FOR TOXICITIES (continued)											
ETHAMBUTOL Dosage Mg	# Meds Delivered # Pills Not Taken										
Comments	Decrease of visual acuity (check with Snellen Chart)										
	Loss of ability to perceive colors green or red										
	Question for any renal disease / Rash										
STREPTOMYCIN Dosage IM	Meds Delivered by Injection										
Comments	Hearing Loss										
	Ringing / Roaring in ears										
	Rash										

IV. OVERVIEW OF COMMUNICABLE DISEASES - TREATMENT, ISOLATION, AND QUARANTINE PROCEDURES (UTAH CODE ANNOTATED, TITLE 26: HEALTH CODE, CHAPTER 6b)

Abbreviations used in overview:

UDOH = Utah Department of Health
LHD = local health department
T/Q/I = treatment, quarantine, isolation
STSI = subject to supervision individual
DC = district court
PH = public health
CD = communicable disease
EI = epidemic infection/s
TB = tuberculosis

Chapter 6b. COMMUNICABLE DISEASES – TREATMENT, ISOLATION, AND QUARENTINE PROCEDURES

26-6B-1. Applicability of chapter—Administrative procedures.
Chapter applies to involuntary T/Q/I applied to individuals by UDOH or LHD's. Provisions of chapter supersede Title 63, Chapter 46b, Administrative Procedures Act.

26-6b-2. Definition of "subject to supervision".
"Subject to Supervision" as applied to an individual means the individual is:

(1) infected/suspected to be infected with a CD that poses a PH threat and who does not take action as required by UDOH or LHD to prevent spread of the disease;
(2) contaminated/suspected to be contaminated with an infectious agent posing a PH threat that could be spread if remedial action is not taken;
(3) in a condition/suspected condition which if treatment is not completed will soon pose a PH hazard;
(4) contaminated/suspected contamination with a chemical/biological agent that poses a PH threat that could be spread if remedial action is not taken.

26-6b-3. Temporary Involuntary Treatment, Isolation, and Quarantine (T/Q/I).

(1) UDOH or LHD having jurisdiction over location where the individual is found may issue an order for individual's temporary involuntary T/Q/I.
(2) An individual, subject to supervision, who willfully fails to voluntarily submit to T/Q/I as requested by UDOH or LHD may be ordered to submit to T/Q/I upon:
    (a) written affidavit of UDOH or LHD stating:
        (i) belief that the individual is likely to fail to submit T/Q/I if not immediately restrained;
        (ii) this failure would pose a PH threat; and

(iii) personal knowledge of the individual's condition or circumstances that lead to that belief; and

(b) written statement by a licensed physician indicating the individual is subject to supervision.

(3) Temporary order issued may:

(a) be issued by UDOH or LHD;

(b) order reasonable T/Q/I for not more than 5 days excluding Saturday, Sunday, and legal holidays unless a petition has been filed in district court.

(4)

(a) Pending issuance of an examination order or an order for T/Q/I an individual under a temporary order may be required to submit to T/Q/I in his/her home, a hospital, or any other suitable facility under reasonable conditions prescribed by UDOH or LHD.

(b) UDOH or LHD, issuing temporary order, shall take reasonable measures, including medical care, as may be necessary to assure proper care related to reason for T/Q/I.

(5) The individual subject to supervision, shall be served a copy of the temporary order, together with the affidavit and the physician's written statement, upon being taken into custody. A copy shall be maintained at the place of T/Q/I.

26-6b-4. Required Notice – Representation by counsel – Conduct of proceedings.

(1)

(a) If subject to supervision individual is in custody, the UDOH or LHD (petitioner) shall provide to the individual written notice of commencement of all proceedings and hearings as soon as practicable, and shall mail notice that a hearing may be held to legal guardian, immediate adult family members, legal counsel, or other persons the individual or DC designates.

(c) If individual refuses to permit release of information necessary for the required notice, the DC will determine extent of notice.

(2)

(a) Counsel may represent STSI in custody. If the individual/others do not provide for counsel, the DC shall appoint counsel in enough time to allow consultation prior to hearing. For an indigent STSI, the county of residence of the STSI shall pay for reasonable attorney fees as determined by DC.

(b) The STSI, petitioner, and all others served notice may appear at hearings to testify, and to present and cross-examine witnesses. The DC may receive testimony of any other individual.

(c) The DC may allow a waiver of the individual's right to appear only for good cause.

(d) The DC may allow participation of the STSI by telephonic means if individual's condition poses a PH threat.

(3) The DC may order the STSI to be moved to more appropriate T/Q/I facility outside of its jurisdiction.

(4) The DC may exclude unnecessary persons from the hearing.

(5) All hearings shall be informal and orderly.

(6) Utah Rules of Evidence applies.

26-6b-5. Petition for an order of involuntary treatment, quarantine, or isolation – Court-ordered examination period.

(1)
- (a) UDOH or LHD may commence proceedings for court-ordered T/Q/I of an STSI by filing a written petition with the DC of the STSI's county of residence.
- (b) The county attorney of the STSI's residence/location shall represent the LHD.

(2) The application shall be accompanied by:
- (a) written affidavit stating:
  - (i) belief that person is subject to supervision;
  - (ii) belief that the individual is likely to fail to submit to T/Q/I if not immediately restrained;
  - (iii) this failure is a PH threat; and
  - (iv) personal knowledge of the individual's condition/circumstances that lead to the belief; and
- (b) written statement by a licensed physician finding the individual subject to supervision.

(3) The DC shall issue an examination order requiring individual to submit to T/Q/I and to be examined to verify infection/condition/contamination if DC finds:
- (a) there is reasonable basis to believe the individual's condition requires T/Q/I pending examination/hearing;
- (b) individual has refused to submit to examination by a health professional as directed by UDOH or LHD or to voluntarily submit to T/Q/I.

(4) If STSI is not in custody, the DC may make its determination and disuse an examination order in an ex parte hearing.

(5) At least 24 hours prior to hearing, UDOH or LHD shall report to the court, in writing, the opinion of qualified health care providers regarding whether:
- (a) individual is afflicted with CD posing a PH threat, contaminated with chemical/biological agent posing a PH threat, or is in a condition posing an immediate PH hazard; or
- (b) diagnostic studies are not complete and whether individual has agreed to comply with necessary T/Q/I; and
- (c) whether the petitioner believes the individual will comply without court proceedings.

26-6b-6. Court determination for involuntary supervision after examination period.

(1) The DC shall set a hearing within 10 business days of the issuance of the examination order unless the petitioner informs the DC prior to the hearing that the individual:
- (a) is not subject to supervision'
- (b) has stipulated to the issuance of an order for involuntary T/Q/I;
- (c) has agreed that T/Q/I are available and acceptable without court proceedings.

(2)

(a) If the individual is not subject to supervision or if T/Q/I are available and acceptable to the individual without court proceedings, the court may terminate the proceedings and dismiss the petition.

(b) If the individual has stipulated to the issuance of an order for T/Q/I, the court may issue an order without further hearing.

(3)

(a) If the examination report proves the individual is not subject to supervision, the court may terminate the proceedings without further hearing and dismiss the petition.

(b) After a hearing at which the individual has the opportunity to be represented by counsel, the court may extend the examination order up to 90 days if the petitioner has reason to believe the individual:

(i) is contaminated with a chemical/biological agent that is a threat to PH;

(ii) is in a condition that exposure to poses a serious PH threat and diagnostic studies have not been completed.

(4) The petitioner shall provide to the DC the following if available at the hearing:

(a) temporary order issued by petitioner;

(b) hospital/facility admission notes;

(c) medical records pertaining to T/Q/I.

(5) This information shall also be provided to the individual's counsel at the time of the hearing or before, if requested.

(6)

(a) The DC shall order T/Q/I if there is a clear and convincing evidence that:

(i) individual is infected with a CD, is contaminated with chemical/biological agent posing a serious PH threat, or is in a condition that will soon pose a PH threat if treatment is not completed;

(ii) there is no appropriate and less restrictive alternative;

(iii) petitioner can provide treatment that is adequate and appropriate; and

(iv) it is in the public interest.

(b) The DC shall immediately dismiss the petition if all of these conditions are not met.

(7) The order for T/Q/I shall designate the period for T/Q/I.

(8)

(a) The order for involuntary T/Q/I may not exceed 6 months without a DC review hearing.

(b) The DC review hearing shall be held prior to the expiration of the court order. At the review hearing, the DC may order T/Q/I for an indeterminate period if the DC enters a written finding determining by clear and convincing evidence that the conditions will continue for an indeterminate period.

26-6b-7. Periodic Review of individuals under court order.

(1) At least 2 weeks prior to the expiration of the court order, the petitioner shall inform the DC the order is about to expire. The petitioner shall reexamine the reasons for the court order, and will discharge the individual if court-ordered T/Q/I is no longer needed and report its action to the DC for a termination of the order. Otherwise, the DC shall schedule a hearing prior to the expiration.

(2) The petitioner shall reexamine the reasons for court-ordered T/Q/I at 6-month intervals for individuals under T/Q/I for an indeterminate period. If T/Q/I is no longer necessary, the petitioner shall discharge the individual from involuntary T/Q/I and report its actions to the court for a termination of the order. If the petitioner determines T/Q/I is still necessary, the petitioner shall send a written report to the DC. The petitioner shall notify in writing the individual and counsel that T/Q/I shall continue, the reasons for the decision, and the right to a review hearing. The DC shall immediately set a hearing date if the request is received.

26-6b-8. Transportation of individuals subject to temporary or court-ordered T/Q/I.

The municipal law enforcement authority shall conduct transportation of an individual to the place for T/Q/I where the individual is located. If the place for T/Q/I is outside of the authority's jurisdiction, or the individual is not located in a municipality, the county sheriff shall transport the individual to place for T/Q/I.

26-6b-9. Quarantine, isolation, and treatment costs.

If an LHD obtains approval from UDOH, the costs that the LHD would otherwise have to bear for involuntary T/Q/I shall be paid by UDOH to the extent that the individual is unable to pay and other sources and insurance do not pay.

26-6b-10. Severability.

If any provisions of this chapter are found unconstitutional, the provision is severable and the balance of chapter remains effective, notwithstanding that unconstitutionality.

VII. Appendix A
Samples of Documentation

Table of Contents (Including Legal Process Timeline)

SECTION 1: Initial Orders and Affidavits

SECTION 2: Stipulated Orders

A. Stipulation to the Issuance of an Order for Involuntary Treatment and Quarantine

B. Order for Involuntary Treatment and Quarantine
- This Order is valid for up to 6 months - Utah Code Annotated § 26-6b-6(8)(a)

SECTION 3: In Case of Evidentiary Hearing

A. Findings of Fact
- Note – If the two parties are unable to agree and submit a Stipulation Order, an Evidentiary Hearing will be held. The results of this Evidentiary Hearing will be fact intensive and specific to the individual's situation. Therefore, this form is provided as an example of Findings of Fact and is not meant to serve as a template.

SECTION 4: Request and Order to Extend Isolation and Treatment Time

A. Stipulation Extending the Effective Time Period
- This Stipulation Request must be submitted prior to the 6 month expiration of the Order - Utah Code Annotated § 26-6b-7(2)

B. Order of Extension of Compulsory Treatment

SECTION 5: Treatment Complete and Release of Individual

A. Motion to Dismiss Case Without Prejudice

B. Order Dismissing Case Without Prejudice

SECTION 6: Reference Material

A. Outline of Procedures Used and Information Needed

B. What to Set Up Well in Advance

C. Possible Problems

D. Summary of Involuntary Treatment Statute

E. Non-Legal Documents
- Information for Persons in Home Isolation or Quarantine
- Instructions for Individuals with a Diagnosed or Suspected Case of a Communicable Disease: Plague, SARS, Smallpox, Viral Hemorrhagic Fever
- Fact Sheets on Various Bioterrorism Agents: Anthrax, Botulism, Plague, Smallpox, Viral Hemorrhagic Fever, Tularemia

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